Acceptance and Commitment Therapy in Obsessive–Compulsive Disorder: A Case Study

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ABSTRACT

Recent years have witnessed an increased interest in the use of "third-wave" psychotherapies in treating psychiatric disorders. These newer therapies are fundamentally different from the existing techniques such as cognitive behavioral therapy in terms of their guiding principles and processes of change. Acceptance and commitment therapy (ACT) is the most prominent among these "third wave" psychotherapies. However, there have not been any reports from India, thus far, that have studied the use of ACT in treating obsessive–compulsive disorder (OCD). We describe a case of OCD that was successfully treated with eight sessions of ACT, with the results being maintained over a one-month follow-up period. Postintervention tests revealed a significant decrease in obsessive–compulsive symptoms and an associated increase in psychological flexibility. This case study highlights the possible utility of ACT as a therapeutic intervention in OCD, especially when combined with pharmacotherapy.

Keywords: Acceptance and commitment therapy, obsessive–compulsive disorder, ACT

Obsessive–compulsive disorder (OCD) is the fourth most common mental illness worldwide, with 1%–3% prevalence in the general population.[1] The hallmark of OCD is the presence of recurrent or persistent thoughts, impulses, or images (obsessions) experienced as distressing by the person and are attempted to be suppressed by performing repetitive mental or behavioral acts (compulsions).[2] Psychotherapeutic techniques, especially exposure and response prevention (ERP), have an established evidence base for treating OCD.[3] However, ERP has drawbacks, such as a relatively high drop-out rate and reduced acceptability among patients.[4] In recent years, there has been an increased interest in the use of "third-wave" psychotherapies in treating psychiatric disorders. These newer therapies are fundamentally different from existing techniques, such as cognitive behavioral therapy (CBT). While traditional CBT is "antecedent-focused" and aims to change the nature of the obsessive thought, the "third-wave" therapies are "response-focused," with an emphasis on changing the relationship between the obsessive thought and the ensuing emotional state. Acceptance and commitment therapy (ACT) is the most prominent among the third-wave psychotherapies. It has garnered considerable interest among mental health specialists as a novel and effective intervention in OCD. A recent systematic review that studied the evidence base for the use of ACT in OCD concluded that ACT produces a considerable reduction in the severity of symptoms in OCD and is as effective as a combination of CBT and pharmacotherapy when used in conjunction with selective serotonin reuptake inhibitors (SSRI).[5] We describe a case of OCD that was successfully treated with eight sessions of ACT, as recommended in the original manual by Hayes, with the results being maintained over a 1-month follow-up period.[6] To the best of our knowledge, this is the first report from India to elaborate on the effective utilization of ACT in treating OCD. This case report aims to familiarize mental health practitioners with the processes of ACT and highlight its possible utility in bringing about clinical improvement in OCD.

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The Patient

G, a 33-year-old married professional, presented with a history of obsessive thoughts and associated compulsions since childhood. Upon evaluation, it was noted that there was a family history of OCD in the patient's mother and obsessive–compulsive personality traits in the maternal grandfather. G had been diagnosed with OCD at the age of 12 years and had a chronic course of the illness, with waxing and waning of symptoms over time. He had suffered from a plethora of symptoms since the onset of his illness, which included magical thinking (during childhood), fears of contamination, compulsive hand washing, repeated checking, and a need for symmetry, which occurred in varying combinations and to different degrees of severity over the years. He had been treated with clomipramine for a few years at the outset, which was later changed to fluvoxamine, owing to its more favorable side effect profile. G had subsequently been on fluvoxamine continuously, without a drug-free interval, albeit with dose adjustments as his symptoms fluctuated in intensity. He had been maintaining well on 150 mg of fluvoxamine until 2 months ago, when his condition deteriorated.

G presented with complaints of increased anxiety, fears of contamination and falling ill, and compulsive hand washing. These symptoms had reportedly been precipitated by the COVID-19 pandemic and exacerbated by recent news of the local spread of the infection within the community. These issues were causing him considerable distress and had begun to interfere with his professional and family lives. G began to take on fewer work commitments that entailed physical meetings with clients, resulting in a pay cut. He refused to visit his elderly parents for fear of unwittingly transmitting COVID-19 to them and had not seen them in over 8 months. He had frequent arguments with his wife and parents-in-law, as he accused them of not taking adequate precautions to safeguard from contracting the illness. Owing to these factors, he reported considerable deterioration in his relationships and quality of life. The presence of a concomitant mood disorder was ruled out with a detailed history. The physical examination was uneventful, and the routine laboratory investigations did not yield anything out of the ordinary.

In consultation with the client, it was decided to employ ACT as a therapeutic intervention to address the symptoms of OCD. This decision was facilitated by the fact that the client was already on adequate pharmacotherapy, since ACT is as efficacious as CBT or ERP when used in conjunction with SSRI. Moreover, there is also evidence that ACT may have a slightly more profound effect on improving patients' quality of life compared to traditional CBT approaches. [5] Since one of the primary aims of the client in seeking therapy was to aspire to live a more value-based life, ACT was chosen as the most suitable treatment for G.

Before initiating therapy, the client was administered the Yale–Brown Obsessive–Compulsive Rating Scale (Y-BOCS) and symptom checklist. The current symptoms were found to be concerns about falling ill, concerns about getting others ill (contamination obsessions), excessive and ritualized hand washing, excessive bathing, and excessive washing of clothes worn outside the home (cleaning compulsions). The total score on the Y-BOCS was 24.

The client's psychological flexibility was assessed using the Acceptance and Action Questionnaire (AAQ-II). Psychological flexibility is broadly understood as the ability to be in contact with the present moment, fully aware, and accepting of one's thoughts and emotions, however distressing they may be. The AAQ-II yielded a total score of 20, which was indicative of moderate to low levels of psychological flexibility and reflected the presence of clinically relevant psychological distress. Ultimately, the goal of ACT was to increase the client's psychological flexibility, and, consequently, relieve his subjective distress.

Intervention Protocol

The core principles and processes of ACT were delivered in an eight-session format of weekly sessions, over a period of 8 weeks. The duration of each session was 1 hour. Every session began with a recap of the skills learned in the previous session and a review of the homework exercise. The first few minutes were spent on a mindfulness-based breathing exercise with the eyes closed, thereby serving the dual purposes of relaxing the client as well as practicing the skill of mindfulness, which forms an integral part of ACT.

In the first session, the client's history was reviewed, the basic premise of ACT was explained, and an outline of the sessions chalked out. A verbal contract was made with the client to follow through with the planned sessions. In the next week, the patient's previous attempts at controlling the obsessive thoughts were explored. G had, for the better part of his illness, attempted to identify and suppress his intrusive thoughts, which, in turn, caused them to become more recurrent and distressing. The futility of attempting to resist the obsessive ruminations was demonstrated using the quicksand metaphor; wherein a parallel was drawn to show that the more one tries to escape quicksand, the deeper one tends to sink. The client was encouraged to see that, on the contrary, simply not struggling to resist unwanted thoughts may enable him to overcome them more easily.

The third session was focused on illustrating to the patient that we are often mistaken in believing that we are in complete control of our own thoughts. Using the "camel in the desert" metaphor, the patient was instructed that he should try his hardest not to visualize a camel in the desert. The patient noticed that in trying to avoid a certain image, however absurd it may be, the exact image presented itself to the center of his consciousness. Hence, the therapist suggested that the client's fervent attempts to avoid obsessive thoughts only served to enforce them and exacerbate their frequency. At the end of the session, the client was asked to record his obsessive thoughts in a thought diary.

In the fourth session, the concept of defusion was introduced. The client was taught to separate the language of the obsessional thoughts from its meaning, thereby defusing the two. To clarify this concept, the therapist instructed the client to repeat the word "milk" continuously until it ceased to represent a word

with meaning, and instead became just a sound. The client was advised that, similarly, defusing the obsessive thought from its literal meaning would strip the thought of its inclination to instigate anxiety, thereby rendering the obsession powerless.

The concept of mindfulness took center stage in the following week. The "leaves on a stream" exercise was introduced, wherein the client was asked to imagine himself sitting by the banks of a stream, watching his thoughts float by like leaves on the surface of the water. The client was taught to visualize his thoughts, whether distressing or otherwise, gently floating by, without responding to each thought at an emotional level. Guided imagery and softly spoken instructions were used to enable the client to achieve a sense of calm during this exercise. G was pleased to find that this exercise "put distance between himself and his thoughts," thereby releasing him from his desire to control them.

The concept of self-as-context was introduced in the sixth session. The chessboard metaphor was used to liken the client to a chessboard and his thoughts to the chess pieces. Like the black and white pieces on the board that are played against each other in the game of chess, so too did the client possess both pleasant and unpleasant thoughts. In a similar vein, just as the events unfolding among the chess pieces during a chess game never changed the chessboard itself, the thoughts within the person's mind would not change the person, i.e., the concept of "self" remained unchanged. This metaphor helped the client visualize his thoughts as distinct from "himself," thereby reducing the distress caused by the obsessive thoughts.

The penultimate session dealt with the "values" component of ACT. The client was asked to envision the values that were most important to him in life and how he envisaged living his best life in pursuit of those values. He was advised to set out goals that he wanted to accomplish, in keeping with the values that were previously identified, and take committed action to work toward those goals. G revealed that he had always found meaning and purpose in helping others to overcome their struggles. Since G's work involved mentoring and coaching new entrants in his profession, it was pointed out that his whole-hearted participation in such endeavors could enable him to live a fulfilling life, despite his anxiety.

The final session focused on reinforcing the principles of mindfulness, accepting distressing thoughts, and defusion of obsessive thoughts from their literal meaning. The skills taught in the preceding weeks were revisited, and the client was encouraged to practice these consistently until they became second nature to him. Ultimately, the obsessive thoughts were reframed as simply a part of the amalgamation of experiences that comprise life, where OCD no longer needed to stand in the way of living a full, enriching, and value-based life.

Overcoming the Hurdles in Providing ACT

When G presented to the OPD, he was distressed by the content of his intrusive thoughts, which he recognized to be unreasonable, but which compelled him to perform compulsive acts to reduce the associated anxiety. He believed that therapy would help him get rid of these unwanted thoughts, or at the very least, change their content, so that he was no longer distressed by them. At first, he was disappointed to learn that ACT, on the contrary, would focus on striving to accept these thoughts so that they no longer interfered with the attainment of cherished goals. The therapist had to work through these misplaced expectations before beginning the therapy but was able to convince the client that the counterintuitive nature of ACT was, in fact, what contributed to its efficacy. Hence, the entire premise of ACT was initially met with skepticism, as its core philosophy was at odds with what the client had expected from psychotherapy. The therapist overcame this by explaining the underlying principles of ACT and how it differed from the more traditional therapies like CBT.

During the initial few sessions, G struggled to learn and apply the principles of mindfulness. Despite striving to focus fully on the present moment, there were invariably some intrusive thoughts that presented themselves into his consciousness at times. The client tended to misconstrue this as evidence that the therapy was not working, which caused him undue frustration. G was supported to accept the presence of the obsessive thoughts while learning to defuse the thought from its literal meaning. The "leaves on a stream" exercise was found to be useful in illustrating this concept. Hence, the therapist was able to help the client by demonstrating that allowing these thoughts to simply "come and go," without responding to them emotionally, was an integral part of ACT.

ACT involves the abundant use of metaphors to drive home its core principles. Some of these metaphors were deemed by the client to be too simplistic and "childish," due to which he sometimes hesitated to follow through with the therapist's instructions, for instance, in reciting the word "milk" loudly and repeatedly to demonstrate cognitive defusion. The therapist had to persuade G to perform these exercises so that he could eventually see that the simplistic nature of the metaphors was what made them so effective in converting complex psychological theories into language that he could easily understand.

Outcome

After completing eight sessions of ACT, the patient was asked to return to the out-patient department after 1 week to reassess the obsessive–compulsive (OC) symptoms and the associated distress. The Y-BOCS and AAQ-II scales were administered once again to quantify the posttreatment OC symptoms. The completed Y-BOCS returned a score of 14, which denoted an approximately 40% decrease in symptomatology from pretreatment levels and represented a significant improvement. The subsections of the Y-BOCS dealing with obsessive thoughts and compulsive behaviors showed a decrease of five points each from their original scores. The client scored a total of 36 on the AAQ-II, which reflected an increase in his psychological flexibility. Specifically, the AAQ-II revealed that the client was no longer unduly distressed by his apparent lack of control over his obsessive thoughts; and he was able to prevent his

TABLE 1.

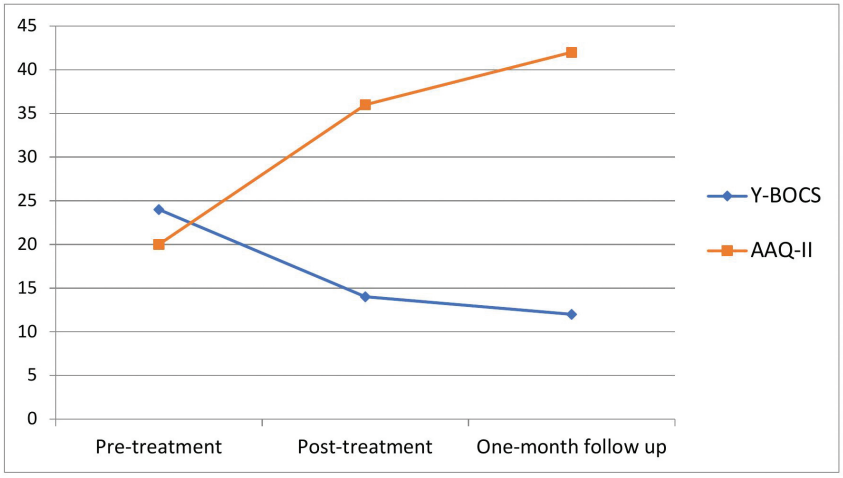
Outcome Measures at Pretreatment, Posttreatment, and 1-Month Follow-Up

	Pretreatment	Posttreatment	1-Month Follow-Up
Y-BOCS	24	14	11
AAQ-II	20	36	42

Y-BOCS: Yale–Brown Obsessive–Compulsive Scale, AAQ-II: Acceptance and Action Questionnaire-II.

FIGURE 1.

Outcome Measures at Pretreatment, Posttreatment, and 1-Month Follow-Up



Y-BOCS: Yale–Brown Obsessive–Compulsive Scale, AAQ-II: Acceptance and Action Questionnaire-II.

obsessions from interfering with living a life based on his cherished values. These gains were found to be maintained at the 1-month follow-up session. Toward the completion of the sessions, G was able to take on more responsibilities at work, reassume his mentorship role at his organization, and have an honest discussion about his OCD with his spouse, who turned out to be the most supportive element in his recovery. G stated the following at his follow-up session: "ACT has allowed me to accept my obsessive thoughts instead of struggling against them, and enabled me to live my life to the fullest despite their existence." The outcome measures are represented in **Table 1** and **Figure 1**.

Discussion

Our case study demonstrates that ACT can play a useful role as a therapeutic intervention in OCD. A literature search revealed that this is the first report from India to record the successful treatment of OCD using ACT. Eight sessions of ACT were noted to significantly reduce the frequency of obsessions and compulsions, with an accompanying decrease in the associated distress. The sessions addressed the six core components of ACT, namely acceptance, cognitive defusion, awareness of the present moment, self-as-context, committed action, and values. Instead of identifying, dissecting, and restructuring the underlying cognitive distortions, the client learned to visualize the obsessive thoughts plainly for what they are, while keeping the emotional distress at bay. In the end, the client was able to work toward living a value-based life where obsessions and compulsions no longer took center stage.

It is common knowledge that the best results are often obtained, in terms of achieving wellness for patients with mental health problems, when pharmacotherapy is combined with the appropriate psychotherapeutic technique.[7] Although CBT and ERP have a strong evidence base for treating OCD, newer psychological techniques like ACT are increasingly employed in recent years as effective alternate interventions. When combined with pharmacotherapy, ACT is as effective as CBT in reducing symptoms of OCD.[5] ACT has also been noted to have greater acceptability and lower drop-out rates than ERP among patients.[4] Moreover, ACT is even more well-suited than ERP in certain subsets of patients, namely those with moderate levels of psychological flexibility and coexisting mood disorders.[8] In our case study, the patient showed a significant clinical improvement on a combination of ACT and pharmacotherapy. Hence, there is scope for ACT to be used by mental health specialists as a robust psychological treatment for their patients with OCD.

The existing literature on the efficacy of ACT in the management of OCD is limited by the short duration of follow-up, which has been restricted to 3 months in the majority of cases.[5] We found that our patient was able to apply the principles of ACT in his day-to-day life so that his improvement was maintained when evaluated during the posttreatment follow-up sessions at 1 week and 1 month after the cessation of ACT. There is a need for long-term follow-up of these patients to determine if the clinical gains are maintained over time.

Conclusion

This is the first report from India to elaborate on the successful treatment of OCD using eight sessions of ACT, as set out in the original manual by Hayes.[6] The improvement in the symptoms of OCD, reduction in the associated distress, and the increase in psychological flexibility were maintained over the 1-month follow-up period. Our study demonstrates that ACT can bring about significant clinical gains in treating OCD, especially when combined with pharmacotherapy.

Declaration of Patient Consent

The authors certify that the patient has given his/her consent to have the relevant clinical

information to be reported in the journal. The authors have obtained all the appropriate patient consent forms. The patient understands that his/her name and initials will not be published and due efforts will be made to conceal his/her identity.

Declaration of Conflicting Interests

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